To: Maine Legislature - Committee on Health & Human Services

Date: Hearting Date April 14, 2021 Re: Testimony on LD 1317

To: Senator Sanborn, Representative Tepler and Honorable Members of the HCIFS committee.

My name is Dr. Zev Myerowitz, and I am the Director of Health Services at Cape Integrative Health (CIH), a 13 provider group located in Cape Elizabeth, ME where I additionally reside. CIH offers primary care, physical therapy, chiropractic, and acupuncture services. We have been in operation for 10 years and CIH performs over 30,000 office visits annually. I additionally serve as vice-president of the Maine Chiropractic Association. My testimony today is in support of the bill before you and to speak as to why this bill is so badly needed.

(PPR) is a tactic currently being abused by Anthem Blue Cross/Blue Shield of Maine to arbitrarily deny claims and withhold payment under the pretense of improving documentation. After a series of records requests, we were notified that CIH was to be placed into pre-payment review. PPR is portrayed to be a goal-oriented partnership to improve provider documentation, however it has been our experience that every single step is intentionally designed to keep offices from exiting PPR, and to delay or deny paying clean claims that would otherwise be subject to 30 day processing rules.

When an office enters PPR, all facility CPT codes or medically necessary services are now no longer allowed to be submitted electronically, and must be paper mailed with all notes to various addresses throughout the country for processing by the insurer's home plan. These notes are then separated from the claim form and scanned in to be sent for review. In today's healthcare all records can be uploaded digitally for a streamlined process, but PPR intentionally requires a paper mailing process for adjudication. This intentionally bypasses document control numbers for the office to track submissions, which seems to be engineered to intentionally create missing claims without clear responsibility on behalf of the insurance company. All modern healthcare offices track claims electronically and implementing a separate tracking system for paper claims with an exceedingly high rate of lost claims places tremendous administrative burden on the provider. Our office produces approximately 1,000 claims a month. Currently 1 out of 7 claims are denied due to scan error rates or miss-handling.

After a period of time, typically 2-4 months, reports are run by the investigators and if the office's claims are better than their arbitrary "fail rates" individual codes remain in PPR until the office improves this calculation and is allowed to exit the process. Denials for reasons outside the purview of PPR are used in this fail-rate, such as denials for patients providing us with the wrong ID number, personal information, or various other reasons that have nothing do due with the intent of PPR and would have been halted by electronic claim scrubbing. There is no transparency from the auditors or investigators to the office, denials are non-standardized and generic. No meaningful information can be gained from denials such as "missing documentation". We currently have hundreds of physical therapy claims that, after 6 months of denials and questioning, the investigator finally revealed that the specific code was denied because

we used the phrase "guided" instead of "monitored" and that this word somehow was interpreted by the auditor that the patient was not supervised. As of today about 1 in 6 claims are capriciously denied reasons such as above.

Paper claims initially denied for missing information or simply lost have no time requirement for processing or notifying the provider of denied claims, and it is up to the provider to manually track these claims. We have had to hire several full time employees, while simultaneously navigating a pandemic, to manually track thousands of paper claims where no communication was received, no explanation of payment was provided, or payments Anthem shows were approved but never actually issued. This is in stark contrast with an electronic clearinghouses where virtually all encounters are tracked in general healthcare operations and insurance companies are subject to penalties for delayed payment processing.

During our 7 months in the PPR process, our delayed account receivables from Anthem BC/BS patients directly as a result of PPR represent nearly half of our entire gross receipts for 2020. As claims are painstakingly corrected, reprocessed, and appealed via mundane and inefficient paper means, we ultimately are paid, but 9-12 months after the encounter. Only at that time will patients eventually receive invoices for services rendered. While this clearly places undue financial hardship upon any office in PPR, patients suffer further as they prevented from utilizing their health reimbursement accounts for the expenses they incur. Everybody loses but the insurer.

I please ask you to vote "Ought to Pass on LD 1317". I'm happy to answer any questions you may have at this time.

Respectfully Submitted,

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